THE SHINE PROGRAM
Serving the Health Information Needs of Elders

MassMedLine™ Toll-Free Prescription Information and Referrals for Massachusetts Residents
1-866-633-1617

ship state health insurance assistance programs
NATIONAL NETWORK
LOCAL HELP FOR PEOPLE WITH MEDICARE

Medicare Drug Plan
Pre-Enrollment Information

SHINE Program –1 800-243-4636, press or say 2

Please Print

Name:_____

Address:_____
Street City Zip Code

Phone:_____ **Medicare #:**_____

Date of Birth:_____ **Preferred Spoken Language:**_____

Effective Date of Medicare A & B:_____Month and Year
Effective Date of Medicare B (if different):_____Month & Year

Place a check next to your current insurance coverage:

Original Medicare and:

- ☐ Blue Cross/Blue Shield Medex Core
- ☐ Blue Cross/Blue Shield Medex Bronze
- ☐ Blue Cross/Blue Shield Medex Gold
- ☐ United Health/AARP Core
- ☐ United Health/AARP Supplement 1
- ☐ United Health/AARP Supplement 2
- ☐ Other Insurance: (i.e.)VA/TRICARE Please name:_____

If you are in a Medicare HMO, please check the appropriate plan:

- ☐ Blue Cross/Blue Shield Blue Care 65
- ☐ Fallon Senior Plan
- ☐ Harvard Pilgrim First Seniority
- ☐ Tufts Health Plan (Secure Horizons)

If you receive coverage through an employer or union (active OR retiree), please provide information:

Does your plan provide prescription coverage?_____

If YES, has it been determined "as good as" Medicare Part D (creditable)?_____

Are you enrolled in Prescription Advantage? Yes___ No___

What Plan have you been auto-enrolled into?_____

If Yes, do you pay a monthly premium for Prescription Advantage? Yes___ No___

Have you completed the "Application for Help with Medicare Prescription Drug Plan Costs"? Yes___ IF YES, were you approved? Yes____ or No _____
No___ IF NO, is your income under $14,355 single or $19,245 couple.

Are you enrolled in MassHealth? Yes___No___
What Plan have you been auto-enrolled in? _____

Do you wish to be able to use mail service? Yes_____No_____

If you go to a particular pharmacy, please list with address:
_____

Please list your current medications below.
Please use additional paper if needed.

DO NOT LIST YOUR OVER THE COUNTER DRUGS!

PRINT CLEARLY

Drugs should be based on a 30 day supply

Drug Name – <u>As written from the Bottle</u> Example: Zantac	**Drug Strength/Dose per Day** 150 Mg/2 a day
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

If you need further assistance, complete and return to:

SHINE, 1 Ashburton Place, 5th Floor, Boston, Massachusetts 02108